Summary of Mental Health and Substance Abuse Benefits for Auburn University PPO Plan

Uprise Health (formerly American Behavioral)

Effective January 1, 2024

Summary Document #: 559777215383

IMPORTANT INFORMATION: All benefits are based on the appropriate level of care and medical necessity guidelines. Provider/facility licensure by the state to provide covered services and facility accreditation by The Joint Commission or CARF is required.

Calendar Year Deductible	**$500** Per Person Per Year with a **Three (3)** Member Family Maximum 4th Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which may have been allocated toward all or a portion of the Calendar Year Deductible for that year may also be allocated toward next year's Calendar Year Deductible
Calendar Year Out-of-Pocket	**$9,450** Individual / **$18,900** Aggregate Family Maximum

1. Your calendar year deductible counts toward your out-of-pocket maximum.
2. The deductible amounts for mental health and substance abuse combine with medical for total deductible.
3. The family calendar year deductible and out-of-pocket maximum is embedded, meaning that each member has his or her own deductible/out-of-pocket maximum in addition to the shared family deductible/out-of-pocket maximum. Any amount paid toward an individual's deductible/out-of-pocket maximum also applies toward the family's deductible/out-of-pocket maximum. This allows individuals in the family to have their costs covered before the family deductible/out-of-pocket maximum has been met. Once the family deductible/out-of-pocket maximum is met, the plan covers charges for any family member.
4. **Deductible Carryover:** When covered charges are applied towards the calendar year deductible for services rendered in October,

MENTAL HEALTH PROGRAM

1. *INPATIENT SERVICES*

Benefits	In-Network	Out-of-Network
• Acute Inpatient Hospitalization • Residential • Inpatient Electroconvulsive Therapy (ECT) • Partial Hospitalization/Day Treatment (PHP) • Intensive Outpatient Program (IOP)	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount After Copay, Subject to Calendar Year Deductible **Patient Responsibility:** **$300** Copay Per Admission Subject to Calendar Year Deductible	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **80%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*

2. *OUTPATIENT OFFICE VISITS*

Description	In-Network	Out-of-Network
Outpatient Office Visits	Covered At **100%** Of Allowed Amount After Copay **Patient Responsibility:** **$30** Copay Per Visit/ Session/Group Therapy Session	Covered At **80%** Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*

3. *PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING*

Description	In-Network	Out-of-Network
Psychological/Neuropsychological Testing	**Precertification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount After Copay **Patient Responsibility:** **$30** Copay Per Visit/Session/Group Therapy Session	**Precertification Required** **Call 800-677-4544** Covered At **80%** Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*

SUBSTANCE ABUSE PROGRAM		
1. INPATIENT SERVICES		
Benefits	**In-Network**	**Out-of-Network**
• Detoxification • Partial Hospitalization/Day Treatment (PHP) • Intensive Outpatient Program (IOP) • Residential Treatment Services	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount After Copay, Subject to Calendar Year Deductible **Patient Responsibility:** **$300** Copay Per Admission Subject to Calendar Year Deductible	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **80%** Of Allowed Amount Subject to Calendar Year Deductible **Patient Responsibility:** All Billed Charges Not Covered by The Plan
2. OUTPATIENT OFFICE VISITS		
Ambulatory Detoxification (Office Visit)	Covered At **100%** Of Allowed Amount After Copay **Patient Responsibility:** **$30** Copay Per Visit/Session/Group Therapy Session	Covered At **80%** Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The Plan
APPLIED BEHAVIOR ANALYSIS (ABA) FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS		
Benefits	**In-Network**	**Out-of-Network**
Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorders **Based on Eligibility and Clinical Criteria Being Met**	**Pre-certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount **Patient Responsibility:** **None** **Exclusion: In-home care not covered**	Covered At **80%** Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The *Plan* **Exclusion: In-home care not covered**
PROFESSIONAL SERVICES		
Benefits	**In-Network**	**Out-of-Network**
Inpatient Physician Services in Conjunction with Approved Inpatient Services	Covered At **100%** Of Allowed Amount **Patient Responsibility:** **None**	Covered At **80%** Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Anesthesia in Conjunction with Approved ECT Treatment	Covered At **100%** Of Allowed Amount Subject to the Inpatient Copay Amount **Patient Responsibility:** **None**	Covered At **80%** Of Allowed Amount **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
COVERED BY MEDICAL PLAN		
• Ambulance • Emergency Department • Imaging • Lab Work	**COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL**	**COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL**
BEHAVIORAL HEALTH CARE MANAGEMENT		
Care management is a service offered by *the Plan* to assist you with difficult behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns. Call Uprise, (formerly American Behavioral) at 800-677-4544 to talk to your personal care manager.		